STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E650	A. BUILDING 01 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS, THE	14409 SUNRISE COURT LEO, IN46765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/12/11 Facility Number: 001215 Provider Number: 15E650 AIM Number: 100450890 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, The Cedars was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies in the extension to the 200 hall and 410 IAC 16.2.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident room. The facility has a capacity of 65 and had a census of 43 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/17/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2			

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	Based on observation and interview, the facility failed to ensure 1 of 5 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome the fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects two of five smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor and the Laundry/Housekeeping Supervisor on 05/12/11 at 2:10 p.m., the fire doors leading to the residential hall failed to close upon activation of the fire alarm. Based on interview with the Maintenance Supervisor at the time of observation, these were fire doors.	K0021	The fire panel in the 200 wing had a broken wire. It was fixed on 5-12-11. During all fire alarm tests a member of the Safety Committee will check all fire doors to ensure proper closing with the fire system. The Maintenance Supervisor will oversee this process to insure the finding does not recur.	05/12/2011

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K0056 SS=E	3.1-19(b) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 4 of 6 sprinkler heads in the extended dining room were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect all resident in the extended dining room in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor and the Laundry/Housekeeping Supervisor	K0056	The removal of two preexisting sprinkler heads that are too close together due to remodeling is scheduled by Koorsen Fire Protection Service. These extra sprinkler heads will be removed by 6-10-2011. The Administrator and Maintenance Supervisor will insure that this finding does not recur.	06/10/2011

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	on 05/12/11 at 1:18 p.m., the two sprinkler heads in the extended dining room near the west entrance measured thirty one and one half inches apart and the two sprinkler heads at the east entrance measured forty six inches apart. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A	K0130	The rolling fire doors were inspected on 5-19-2011 by Fort Wayne Doors, Inc.. The rolling doors will be annually inspected from this date forward. The Maintenance Supervisor will also do precautionary checks periodicly to see that the rolling doors are in good working order.	05/19/2011

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	written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room. Findings include: Based on observation with the Maintenance Supervisor and Laundry/Housekeeping Supervisor on 05/12/11 at 1:20 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. The rolling fire door was not in a corridor wall. Based on interview with the Maintenance Supervisor at the time of observation, there was no documentation of an annual inspection or test to check for proper operation. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and	K0144	An automatic emergency storp	06/10/2011

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	interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor		will be installed and located in the building near the internal gauges. Reuest Interprises, Inc., Columbia City, has been asked to install this piece of equipment in accordance with the new regulations. The Maintenance Supervisor will oversee this installation.	

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	on 05/12/11 during a tour of the facility from 11:20 a.m. to 2:10 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Supervisor at 11:20 a.m., the generator engine was rated at 400 horsepower. 3-1.19(b)			